Cultural Determinants in Conversation Approach to Family Mental Health in Isukha Central, Kakamega

Pelesiah Okuthe[1*], Jerry Agalo[2], James Abila[3] & Millicent Otieno[4]

[1]*Department of Communication, Media & Journalism, Rongo University, Kenya (awuorjp@gmail.com)*

[2]*Department of Communication, Media & Journalism, Rongo University, Kenya*

[3]*Department of Information, Health Records and Systems, Rongo University, Kenya, (abisonj@rongovarsity.ac.ke)*

[4]*Department of Communication, Media & Journalism, Rongo University, Kenya (millyotieno@yahoo.com)*

**Corresponding author: awuorjp@gmail.com*

https://doi.org/10.62049/jkncu.v5i1.415

Abstract

Conversational approach is increasingly recognized as a central determinant of family mental health. It functions as a relational process nurturing trust, emotional expression, and shared coping. Globally, it is increasingly recognized as a driver of family mental health. In many African societies, including Kenya, conversations are shaped by deeply rooted cultural norms and communal value systems. Isukha Central in Western Kenya presents a culturally distinct context, characterized by strong traditional practices and tightly knit community structures. Anchored in Communication Accommodation Theory, this study investigated how indigenous cultural norms, values and conversational approach influence family mental health. Adopting a qualitative case study with a narrative orientation guided by an interpretivist-constructivist paradigm, data was collected through in-depth interviews and focus group discussions. Purposive and snowball sampling strategies were used; thematic analysis was conducted using NVivo. The findings enrich the growing body of knowledge on culturally responsive family mental health strategies in Sub-Saharan Africa, providing practical insights for policymakers, practitioners, and researchers seeking to bridge traditional knowledge systems with contemporary mental health frameworks. The study concludes that culturally responsive conversational approaches integrating traditional values with mental health literacy are essential for strengthening family-based mental health interventions. Thereby, contributing to Sustainable Development Goal No. 3 on ensuring healthy lives and promoting well-being for all.

Keywords: Cultural Determinants, Conversation Approach, Family, Mental Health

Introduction

The conversation approach is increasingly recognized as a key determinant of family mental health, influencing emotional expression, trust, and collective coping. Globally, research indicates that supportive family conversations promote mental health, resilience, and effective stress management (Saul & Simon, 2016). However, conversation is not culturally neutral, conversational approach is shaped by norms, values, and social expectations that dictate how emotions are expressed, conflicts are resolved, and support is provided. The study was guided by the following objective to examine the influence of conversation approach on culture towards family mental health in Isukha Central. In African societies, cultural norms strongly influence family conversation. Hierarchical structures, communal values, and traditional practices guide who speaks, what topics are discussed, and how emotions are displayed (Atilola, 2019; Nwoye, 2020). These norms may either enable open emotional sharing or constrain discussion of sensitive issues, including mental health.

In Kenya, studies have largely focused on mental-health awareness, help-seeking behaviours and stigma at community or institutional levels (Mutiso et al., 2020; Muga & Jenkins, 2019). Despite national reforms, including the 2025 decriminalization of attempted suicide aimed at destigmatizing mental illness, there remains a gap in understanding how local cultural norms interact with conversational approaches to shape family mental-health outcomes. Existing research rarely addresses how culturally rooted conversation styles influence emotional disclosure, coping, and relational support within families. At the local level, Isukha Central in Kakamega County, Kenya represents a culturally distinct setting where traditional practices, communal cohesion, and indigenous values continue to shape family interactions. Families navigate emotional support, conflict resolution, and mental-health discussions within these cultural frameworks. Yet, empirical evidence on how these norms influence conversational practices and, in turn, family mental-health outcomes is limited. Understanding these dynamics is essential for designing culturally sensitive interventions that strengthen family-based mental-health support.

This study, therefore, examines the cultural determinants that shape conversational approaches to family mental health in Isukha Central. By exploring local conversation norms and practices, it seeks to illuminate how culture shapes the ways families talk, support one another, and respond to mental health challenges.

Literature Review

Conversation within families is increasingly recognized as a central determinant of mental health, not merely as an exchange of words but as a relational process that sustains trust, emotional expression, and collective coping. The conversation approach emphasizes availability, listening, openness, feedback, and empathy as key communicative behaviors that foster resilience and well-being in family systems (Zhang et al., 2023). When such conversations are frequent and supportive, families are more likely to identify psychological distress early, reduce stigma, and encourage help-seeking (Lee & Koerner, 2023). Conversely, when conversation is constrained by silence, conflict-avoidant patterns, or cultural restrictions, mental health vulnerabilities are often exacerbated.

In Kenya and similar collectivist African societies, cultural beliefs deeply shape how families talk or remain silent about distress. Studies show that secrecy and denial often emerge as culturally sanctioned strategies to “protect” family reputation, while self-guilt and isolation reflect internalized stigma tied to communal expectations and moral interpretations of illness (Muiruri et al., 2023). Taboos around discussing suicide,

depression, or substance use further narrow the scope of acceptable family talk, reinforcing silence at moments when open dialogue is most needed (Kenya Ministry of Health, 2021). These cultural determinants intersect with conversation approaches, while the ideals of openness and empathy are theoretically protective, their practice is often constrained by traditions that privilege conformity, respect for elders, and the safeguarding of family honor (Ritchie et al., 2023).

Mental health is increasingly recognized as a critical component of individual health, with family systems playing a central role in enhancing family mental health, according to World Health Organization (WHO, 2021), mental health conditions affect around one in four people globally. In sub-Saharan Africa, where formal mental health services are limited and often inaccessible, the family serves as a primary site for emotional support, caregiving, and early intervention. However, the ways in which families discuss, interpret, and respond to mental health challenges are profoundly shaped by cultural contexts. In many African communities, including Isukha Central in Western Kenya, cultural beliefs and communicative norms significantly influence how mental health is conceptualized, articulated, and addressed within familial settings. The study examines how culturally embedded values, symbols, and social expectations shape conversation around family mental health. within family units. Isukha Central, predominantly inhabited by the Isukha sub-group of the Luhya ethnic community, presents a unique cultural setting where traditional authority structures, spiritual beliefs, and kinship systems continue to shape health-related behavior. The journey towards transforming mental health in Kenya gathered momentum following the launch of the Kenya Mental Health Action Plan (2021-2025).

Despite growing global attention to mental health, scholarly inquiry into culturally grounded conversation practices within African families remains limited (WHO, 2020). Most existing mental health interventions are informed by Western models that often overlook or inadequately integrate indigenous knowledge system. This oversight can result in culturally dissonant approaches that fail to engage families effectively or sustain behavioral change. Consequently, there is a pressing need for context-specific research that illuminates how culture operates as both a resource and a barrier in family mental health discourse. Segrin & Flora (2018), the intersection of culture, conversation, and mental health has attracted growing scholarly attention in recent decades, particularly as global mental health initiatives seek to localize interventions within culturally diverse communities. The interplay between culture, conversation and mental health is increasingly recognized as pivotal in shaping mental health outcomes, particularly within African contexts (Anderson, Anderson & Gehart, 2023). This review synthesizes key literature across four domains relevant to this study: family as a site of mental health promotion, cultural constructions of mental health, conversation and mental health discourse, and the African context, with a focus on indigenous frameworks and community-based approaches to mental health. Families play a foundational role in shaping individual mental health routes, they are central to the promotion and maintenance of mental health, serving as primary sources of emotional support and care. Culture profoundly shapes the ways in which mental health is understood, discussed, and treated. In many African societies, mental health is attributed to supernatural causes such as witchcraft, spirit possession, or ancestral displeasure (Atilola, 2015). Such beliefs can either facilitate community-based support mechanisms or reinforce stigma and marginalization.

Isolation was reported in multiple forms emotional withdrawal, being left out during conversations, or physical distancing during periods of emotional struggle. Instances of discrimination based on gender roles and mental health labels were shared, cultural norms often favor suppressing emotional expression in males

and stigmatize emotional fragility in females. This internal family discrimination discourages help-seeking behavior, especially among youth, cultural taboos discourage any mention of mental health, equating such topics with disrespect or spiritual danger (Segrin & Flora, 2018). This contributes to a household atmosphere of fear and silence, worsening internal mental health struggles (Azcárate-Cenoz et al, 2024). Tension was observed to rise from unresolved disputes, misunderstandings, and financial constraints. These elements, when compounded with silence and denial, foster emotional fatigue within households. Information hiding was common ranging from undisclosed health diagnoses to financial challenges and past traumas. Many respondents internalized blame for family breakdowns or parental conflict. Particularly among women and youth, guilt appeared tied to culturally imposed roles and unrealistic expectations. This contributes to a cycle of low self-worth and hidden suffering, rarely discussed or treated. Denial, secrecy, and misperception strained sibling and parent-child conversations, where there was openness, families reported a marked difference in cohesion and mutual emotional support.

Misinformed beliefs such as associating mental health with witchcraft or curses were commonly held. These cultural misperceptions discouraged open discussion and reinforced silence, families unaware of the psychological nature of distress often resorted to prayer-only approaches, ignoring psychological aid. Many older members resisted change in conversation culture, thus perpetuating emotional inaccessibility. Effective conversation within families is crucial for mental health promotion, however, conversations about mental health are often constrained by taboos, generational power dynamics, and emotional discomfort. In many cultural contexts, especially those with hierarchical family structures, conversation flow is often unidirectional, limiting younger or more vulnerable family members' ability to express distress or seek help. In many African cultures, discussing mental health issues is taboo, leading to silence and lack of support for affected individuals. Efforts to integrate mental health education into community settings aim to break these barriers and encourage open dialogue. Research in rural Kenya and other East African regions suggests that culturally resonant conversation patterns, such as storytelling, idioms, communal dialogue (baraza), and proverbs, can serve as effective mediums for mental health discourse (Ndetei et al., 2019). However, the extent to which such cultural tools are mobilized within families for mental health purposes remains underexplored.

Recent policy shifts and social changes in Kenya highlight the urgency of this tension. The High Court's 2025 ruling decriminalizing attempted suicide has begun to challenge entrenched taboos, opening space for families to speak more openly about suicidality without fear of legal repercussions (The Guardian, 2025). Yet, in contexts such as Isukha Central in Kakamega County, where extended kinship, communal decision-making, and deep respect for customary norms still frame daily life, cultural barriers to open mental-health talk remain powerful. Silence motivated by secrecy, denial, and taboo continues to dominate sensitive conversations, often leaving those experiencing psychological distress to suffer in isolation.

This study therefore investigates the cultural determinants that influence the adoption or obstruction of a conversational approach to family mental-health enhancement in Isukha Central. By thematically examining secrecy, denial, self-guilt, isolation, and taboos, the study seeks to illuminate how cultural norms interact with family conversation practices, and how reconfiguring conversation within these cultural realities could enhance mental-health outcomes.

Problem Statement

Conversation approach, emphasizing openness, empathy, availability, listening, and feedback, has been identified as a key determinant of positive family mental-health outcomes (Zhang et al., 2023). However, its effectiveness is not universal, as the practice of conversation is mediated by cultural norms and belief systems. Mental health challenges are rising in Kenya, yet family responses remain constrained by cultural conversation norms, it is increasingly recognized as a pressing public health concern, with rising rates of depression, anxiety, and suicidality affecting families and communities (Kenya Ministry of Health, 2021). In Isukha Central, Kakamega County, conversational practices are deeply influenced by cultural determinants such as secrecy, denial, self-guilt, isolation, and taboos, which often limit families' ability to openly discuss issues of mental health. While intended to protect family honor and preserve social harmony, these cultural patterns silence conversation around sensitive issues such as depression, suicide, and substance abuse, thereby undermining the protective role of family conversation. Despite Kenya's progress in mental-health reforms, including the 2025 decriminalization of attempted suicide that reflects a national push toward destigmatization, there remains a gap in understanding how local cultural norms interact with a conversation approach to shape family mental-health outcomes. Previous studies have largely focused on general mental-health awareness, service-seeking behaviour and stigma at community or institutional levels (Saul & Simon, 2016). Other research in African contexts examined cultural beliefs surrounding mental illness and family roles in emotional support (Nwoye, 2020). However, few studies have specifically explored how culturally rooted conversational approach within families influence the expression of mental health, relational support, and collective coping. This limited attention to the cultural determinants of family conversation leaves a critical gap in understanding how mental-health outcomes are shaped in culturally distinct settings such as Isukha Central. This oversight presents a critical gap, particularly in rural African contexts where family conversations are a primary means of socialization and emotional support. Existing conversation approaches developed in Western contexts fail to capture these cultural realities, creating an urgent need for context-specific inquiry in Isukha Central.

Research Gap

While existing literature affirms the influence of culture on both conversation and mental health understanding, there is scarcity of studies that explicitly investigate how cultural norms shape family-level conversations on mental health. Moreover, empirical research on Isukha community remains limited, despite its rich cultural traditions and relevance to broader Western Kenyan sociocultural dynamics. This study addresses this critical gap by focusing on how culture informs conversational approaches to family mental health in Isukha Central. It aims to offer nuanced insights that bridge global mental health discourse with localized, culturally grounded realities.

Methodology

The study was conducted in Isukha Central, Kakamega County, Kenya, a rural community characterized by collectivist traditions, extended family structures, and cultural norms that strongly influence interpersonal conversation. This study employed a qualitative phenomenological design within a constructivist–interpretivist paradigm. It was chosen because it allows exploration of the lived experiences of families in Isukha Central, providing deep insights into how cultural determinants shape conversational practices around mental health (Creswell & Poth, 2018; Moustakas, 1994). The target population included

family members, youths, parents, and elders who had experience with family conversations around sensitive issues, including mental health. Purposive and snowball sampling were used to identify participants. The study engaged 26 participants in individual interviews and 24 participants across three focus group discussions (FGDs). Sample size was guided by the principle of data saturation, achieved when no new themes emerged (Guest, Namey, & Chen, 2020). Data was collected using primary and secondary sources. Primary data were obtained through interviews, which enabled participants to share personal narratives regarding cultural determinants such as secrecy, denial, and taboos, and their influence on family conversations. Focus Group Discussions (FGDs) provided collective insights into shared cultural norms and allowed observation of conversational dynamics within a group setting. Secondary data were gathered from existing literature, reports, government documents, and relevant policy frameworks on the conversation approach and family mental health in Kenya. This triangulation of primary and secondary data provided a richer understanding of the cultural factors shaping conversation approaches and helped to situate local findings within broader national and regional contexts. Data was analyzed thematically using Braun and Clarke's (2006) six-step framework**.** NVivo software was used to organize data, generate themes, and ensure systematic analysis.

Findings and Discussion

Cultural Influence on Conversation Approach in Enhancing Family Mental Health

The study revealed how deeply culture is woven into the conversational fabric of families and how this contributes to the mental health of household members. Most families share cultural values, which is essential for grounding identity and shaping mutual understanding in daily interactions. As one respondent explained,

"We make time to tell our children stories of our ancestors so they can grow knowing who they are."

Cultural practices are actively lived, not just discussed. This provides children with experiential learning, reinforcing behavioral expectations and coping strategies. The study revealed that openness fosters belonging and mental resilience. Sharing cultural narratives with children strengthens generational links. As one mother noted,

Our grandmother's stories helped us laugh and think at the same time; we try the same with our kids.

Most households share culture and open discussions with children leading to storytelling highlighting a pattern of structured cultural mentoring. Morality emerges as a pivotal guide in conversations, often informing discipline and intergenerational respect. A father said,

When correcting a child, we talk about what is right and what our people believe is good behavior.

Parenting practices are guided by cultural understandings of responsibility and respect, with few families diverging. Religion is nearly universal in family values and is used as a moral compass during family conversations. As one youth remarked,

Even when I mess up, I'm told to think about what God would want.

Both religion and gender roles influence parenting and conversations around morality, suggesting a layered structure where spiritual belief supports and reinforces cultural norms (Weber & Pargament, 2014). The use of indigenous language preserves identity and deepens emotional connection. Non-verbal cues carry heavy cultural meaning in conversations and are widely recognized. Cultural values are reflected in many things reinforcing cultural pride. There is increasing openness yet a small percentage of silence signals existing tension around taboo subjects. Stigma related topics remain sensitive, especially concerning mental health, but shared space for dialogue strengthens relationships and trust crucial for tackling sensitive and difficult topics like mental health.

Analysis of interviews and FGDs revealed five major cultural determinants shaping the application of conversation approach to family mental-health enhancement in Isukha Central: secrecy, silence, denial, self-guilt, isolation, stigma and taboos. These themes reflect cultural logics that moderate the openness, empathy, and feedback central to the conversation approach, thus influencing family mental-health outcomes.

Identified Themes

Secrecy

Secrecy was a dominant cultural practice, often motivated by the desire to protect family honor and maintain social reputation. Participants described how mental-health struggles were concealed from outsiders, even within the extended family. Such concealment restricted opportunities for shared support and early intervention.

When one young man suffered a mental breakdown, he was secretly taken to a traditional healer. Others were told he had travelled. No one knew the truth. P19.

Similar patterns have been documented across African contexts, where concealment of mental illness is seen as preserving family dignity but often exacerbates stigma and delays help-seeking (Mutiso et al., 2020; Muga & Jenkins, 2019).

Denial

Denial surfaced as a major obstruction in dealing with mental health matters within families. Cultural beliefs in Isukha Central often equate mental health issues with spiritual weakness or curses, making acceptance difficult. This resistance to acknowledge distress leads to delayed intervention and concealed suffering, amplifying the mental health burden silently (Mahatthanadull & Mahatthanadull, 2020.

"We don't talk about such things. If someone looks disturbed, we say they will be okay tomorrow." [Female, 34].

Denial appeared as both a personal and collective coping strategy. Families frequently dismissed mental-health symptoms, reframing them as temporary stress or spiritual weakness. This tendency minimized the seriousness of distress and discouraged empathetic conversation.

I tried to talk to my father about how I felt, but he told me men do not complain so, I stopped and kept quiet. I still hurt" FGD, male, 30s.

Prior studies highlight denial as a common cultural defense mechanism against stigma, one that reinforces silence rather than enabling constructive conversations (Kola et al., 2021; Osafo et al., 2018). Denial within family conversation obstructs recognition, delays care, and discourages open conversation, worsening the mental health outcomes of both individuals and the broader family system.

Silence

Silence was another recurring theme that characterized the cultural approach to conversations on mental health within families in Isukha Central. The data revealed that many families adopted silence both intentional and unconscious as a way of managing distressing emotions, avoiding conflict, and maintaining social decorum. This silence, however, often concealed deep emotional suffering and led to unmet mental health needs. Participants described silence as both a personal and collective strategy shaped by longstanding cultural values, where talking about one's mental or emotional struggles is seen as inappropriate, especially in multigenerational households.

My mother always kept quiet when my father got angry. She used to tell me, 'Say nothing, silence brings peace even if you are hurting'" P25.

According to Gureje et al. (2019), this kind of silence can hinder emotional resilience and worsen mental health outcomes in the long term. Some participants reflected on how silence led to personal isolation. A culture of silence, deeply embedded in the family fabric, was noted in the study. Avoidance of sensitive topics was either intentional or cultural, often linked to the fear of shame or being perceived as weak, this was cited by one participant.

Even if I notice my brother is not okay, I won't ask. We were taught to mind our own." [Male, 27].

This behavioral silence restricts the development of a support system within the family, creating emotional distance (Dorell et al 2017). The cultural belief that revealing too much brings shame or spiritual attack reinforces this pattern,

Even if my mother was struggling, she would never say. I only learned years later. [Male, 38], such patterns deprive family members of the opportunity to offer empathy or aid.

Individual Isolation, Guilt and Self Blame

Participants reported feelings of internalized blame, often perceiving mental health as evidence of moral failure or weakness. This self-guilt silenced disclosure, with individuals fearing they would burden others or bring shame to their families. Literature confirms that guilt and self-stigma are prevalent in African societies where illness is moralized, thereby limiting supportive family conversation (Gureje et al., 2019; Thornicroft et al., 2022).

I stopped talking to people. I felt no one could understand my problems. I spent many days alone. P12.

Isolation emerged as both imposed and self-chosen. Individuals with mental-health challenges often withdrew to avoid judgment, while families sometimes excluded them from decision-making or social events.

When I tried to talk about my thoughts, they belittled me. I stopped speaking altogether and chose to isolate myself. FGD, male, 25.

This undermined the conversation approach's principle of availability and relational closeness. Prior research shows that cultural exclusion mechanisms, often justified as protecting the family image, deepen psychosocial suffering and limit informal support (Ndetei et al., 2020; Abbo, 2018).

Taboos

Certain mental-health topics particularly suicide, substance use, and depression were described as "unspeakable." Deep-rooted taboos discouraged open discussion, reinforcing fear and silence.

In our community, if you say someone has a mental illness, it's like declaring them cursed. We don't talk about such things openly. FGD, elder woman, 60s.

These taboos mirror findings from other African contexts, where cultural prohibitions make conversations about mental health difficult, perpetuating stigma and treatment gaps (Ventevogel, 2021; Osafo et al., 2015).

Stigma and Shame

Stigma and shame emerged as deeply rooted cultural constructs that significantly hindered family conversations around mental health in Isukha Central. These two themes often operated together stigma referring to the negative labels, stereotypes, and social judgments associated with mental and shame being the internalized emotional response that leads individuals and families to feel disgraced, embarrassed, or unworthy. The data revealed that stigma surrounding mental health was widespread, often leading families to hide affected members, deny their condition, or withdraw from social engagement altogether. Participants described mental illness as being perceived not merely as a health issue but as a moral failing, a sign of family dysfunction, or even spiritual punishment. One woman shared,

If people know there's someone with mental issues in your family, they begin to avoid you. Some won't even greet you. It's a great shame. FGD, female, 40s.

Summary of Findings

The findings suggest that while the conversation approach emphasizes openness, empathy, and feedback, its effectiveness in Isukha Central is constrained by cultural determinants. Secrecy, silence, denial, self-guilt, isolation, stigma and taboos act as conversational barriers that weaken the protective role of family conversation. These results affirm the need for culturally adapted conversational models that address stigma and silence while leveraging existing communal strengths.

Conclusion

The data revealed a rich interplay between cultural foundations and conversation in the family. This study sets out to examine how cultural determinants shape the effectiveness of the conversation approach in enhancing family mental health in Isukha Central, Kakamega. The findings demonstrate that while conversation approach anchored in openness, empathy, listening, availability, and feedback offers a strong framework for fostering resilience and reducing stigma, its impact is significantly moderated by cultural

practices. Themes of secrecy, silence, denial, self-guilt, isolation, stigma and taboos emerged as powerful themes that restrict open conversation within families. These cultural dynamics silence conversations around sensitive mental-health issues, delay disclosure, and intensify stigma, thereby undermining the protective function of family conversation.

However, the persistence of silence around certain taboos and stigmas signal that while families are talking, some topics remain partially veiled. The co-existence of high openness with select reticence reflects a transitional cultural state, one foot grounded in tradition, the other stepping towards progressive familial discourse. The analysis underscores a culturally embedded silence that defines family conversation in Isukha Central. While these behaviors are deeply rooted in tradition, their consequences emotional isolation, relational breakdown, and worsening mental health are urgent. Respect for elders and tradition remains strong, there is an emerging tension between silence and expression, hierarchy and inclusivity. Shifting towards culturally sensitive, inclusive, and responsive conversation patterns is not just desirable but necessary for improving family mental health. The study therefore concludes that family mental health in Isukha Central cannot be enhanced by conversation alone; it requires a culturally attuned application of the conversation approach that acknowledges and addresses the realities of local norms, beliefs, and traditions.

Recommendations

From the study, it is important to integrate culturally responsive conversation strategies in mental health interventions, where mental health programmes should incorporate local cultural norms and values by addressing secrecy, denial, and taboos directly, including respect for traditional authority structures, communal decision making and embracing indirect modes of conversation. These strategies can foster trust and engagement within families, facilitating more open and supportive conversations on mental health.

Developing family based mental health education programmes is crucial, if well-tailored, it can create awareness on mental health conversation and demystify the notion of negative conversation and perception. This will emotionally support conversation within households, the programs should use culturally appropriate language, idioms and storytelling formats to ensure relevance and acceptance.

Engagement of cultural gatekeepers where elders, clan leaders, and faith leaders hold significant influence in Isukha communities. Involving them in mental-health sensitization can help shift narratives around silence and secrecy, legitimizing open family conversations.

Strengthening the conversation approach, training programs for parents, caregivers, and young people should emphasize empathetic listening, timely feedback, and openness while demonstrating how these practices can coexist with cultural values of respect and communal harmony. Mental health professionals and community health workers operating in Isukha Central should receive training on local cultural dynamics and conversational norms. This would enable them to deliver services that align with the lived realities and conversation patterns of the community.

Promoting intergenerational conversation initiatives that can encourage conversation across age groups within families should be promoted to bridge generational conversation gaps. These platforms can empower youth to express mental health concerns while still respecting cultural expectations around difference and hierarchy. Continuous community-based participatory research should be supported to ensure that mental

health interventions remain responsive to evolving cultural norms. Engaging local residents in research and program design enhances ownership and sustainability. Collaborate with churches, institutions and local cultural forums to integrate mental health messages into existing social and spiritual platforms. These spaces can serve as entry points for changing attitudes and fostering family-level conversations around mental health.

Policy and legal reinforcement, building on Kenya's recent reforms such as the 2025 decriminalization of attempted suicide, policies should strengthen family and community-level platforms where sensitive issues can be safely discussed without stigma.

Future research should examine how generational differences, gender roles, and socio-economic factors intersect with cultural determinants to shape family conversations on mental health. Comparative studies across other Kenyan communities could also broaden understanding and support the development of a context-specific Conversation Approach Model for African settings.

References

Abbo, C. (2018). Profiles and experiences of people with mental illness in Africa. *International Review of Psychiatry, 30*(6), 523–532.

Anderson, H., Anderson, H., & Gehart, D. R. (2023). Collaborative Dialogic Practice.

Atilola, O. (2015). Level of community mental health literacy in sub-Saharan Africa: current studies are limited in number, scope, spread, and cognizance of cultural nuances. *Nordic Journal of Psychiatry, 69*(2), 93-101.

Azcárate-Cenoz, N., Canga-Armayor, A., Alfaro-Díaz, C., Canga-Armayor, N., Pueyo-Garrigues, M., & Esandi, N. (2024). Family-oriented therapeutic conversations: a systematic scoping review. *Journal of Family Nursing, 30*(2), 145-173.

Bernardi, D. A., & Steyn, F. (2021). Developing and testing a Christian-based program to address depression, anxiety, and stress in intimate partner violence. *Journal of Religion & Spirituality in Social Work: Social Thought, 40*(1), 39-67.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage.

Di Gregorio, S. (2000, September). Using Nvivo for your literature review. In *Strategies in qualitative research: Issues and results from analysis using QSR NVivo and NUD* IST Conference at the Institute of Education, London* (pp. 29-30).

Dorell, Å., Isaksson, U., Östlund, U., & Sundin, K. (2017). Family health conversations have positive outcomes on families-a mixed method research study. *The Open Nursing Journal, 11*, 14.

Gammage, R. J., & Nolte, L. (2020). Family understanding and communication about an adult relative's mental health problem: A systematic narrative review. *Journal of Psychiatric and Mental Health Nursing, 27*(6), 763-788.

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLOS ONE, 15*(5).

Gureje, O., Oladeji, B., Montgomery, A. A., Bello, T., Kola, L., & Olley, B. O. (2019). Stigma and self-stigma in African settings: A review. *World Psychiatry, 18*(2), 150–158.

Kenya Ministry of Health. (2021). *Kenya Mental Health Action Plan 2021–2025*.

Kola, L., Kohrt, B. A., Hanlon, C., Naslund, J. A., Sikander, S., Balaji, M., … & Patel, V. (2021). COVID-19 mental health impact in low-resource settings: Vulnerabilities and needs. *The Lancet Psychiatry, 8*(6), 538–546.

Lee, S. Y., & Koerner, A. F. (2023). The role of family communication patterns in intergenerational health discussion and prevention during COVID-19. *International Journal of Environmental Research and Public Health, 20*.

Mahatthanadull, S., & Mahatthanadull, S. (2020). Human Behaviors in Promoting Balance of Family according to Buddhist Psychology.

Muga, F. A., & Jenkins, R. (2019). Public perceptions, explanatory models and service use among people with mental illness in Kenya. *Social Psychiatry and Psychiatric Epidemiology, 54*(6), 659–667.

Muiruri, P., et al. (2023). Mental health literacy in Turkana, northern Kenya: An ethnographic study. *International Journal of Mental Health Systems*.

Mutiso, V., Musyimi, C., Musau, A., Gitonga, I., Tele, A., Mathai, M., & Ndetei, D. M. (2020). Stigma-related experiences and psychosocial impact among people with psychosis in Kenya. *BMC Psychiatry, 20*(1), 389.

Ndetei, D. M., Mutiso, V. N., & Maraj, A. (2019). Mental Health Service Delivery in Kenya. In *Mental Health Services in Disasters* (pp. 111 – 122). Springer, Cham.

Ndetei, D. M., Mutiso, V., Musyimi, C., & Musau, A. (2020). Traditional healers and provision of mental health services in Kenya. *International Journal of Mental Health Systems, 14*(1), 73.

Osafo, J., Akotia, C. S., Andoh-Arthur, J., & Quarshie, E. N. (2018). Psychological distress and help-seeking behavior among Ghanaian adults. *International Journal of Social Psychiatry, 64*(6), 496–505.

Osafo, J., Hjelmeland, H., Akotia, C. S., & Knizek, B. L. (2015). The paradox of talking about suicide in Ghana: A qualitative study. *Suicide and Life-Threatening Behavior, 45*(2), 251–262.

Repetti, R. L., Robles, T. F., & Reynolds, B. M. (2014). *Handbook of Socialization: Theory and Research*.

Ritchie, L., & colleagues. (2023). Exploring relationships between family communication patterns and health talk. *International Journal of Communication, 17*.

Salami, B., Salma, J., Denga, B., Maduforo, A., & Alaazi, D. A. (2025). Methodological reflections from a research project on the mental health of Black youth. *Health Promotion and Chronic Disease Prevention in Canada, 45*(4).

Saul, J., & Simon, W. (2016). Building resilience in families, communities, and organizations: A training program in global mental health and psychosocial support. *Family Process, 55*(4), 689-699.

Segrin, C., & Flora, J. (2018). *Family communication*. Routledge.

Soliz, J., Thorson, A. R., & Ritternour, C. E. (2009). Communicative Correlates of Satisfaction, Family Identity, and Group Salience in Multiracial/ethnic families. *Journal of Marriage and Family, 71*(4), 819-832.

Thornicroft, G., Sunkel, C., Alikhon Alim, S., Baker, S., Brohan, E., … & Sartorius, N. (2022). Stigma and discrimination in mental health care: Research priorities and global perspectives. *The Lancet Psychiatry, 9*(2), 114–122.

Vangelisti, A. L. (Ed.). (2013). *The Routledge handbook of family communication*. Routledge.

Ventevogel, P. (2021). Mental health and culture in sub-Saharan Africa. *Transcultural Psychiatry, 58*(2), 245–258.

Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health. *Current Opinion in Psychiatry, 27*(5), 358-363.

World Health Organization. (2020). *Mental Health: Strengthening our Response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strenthening-our-response

World Health Organization. (2021). *Mental Health*. Retrieved from https://www.who.int/health-topics/mental-health

Zhang, X., et al. (2023). Family communication, family violence, problematic internet use, anxiety and depression. *BMC Public Health, 23*.